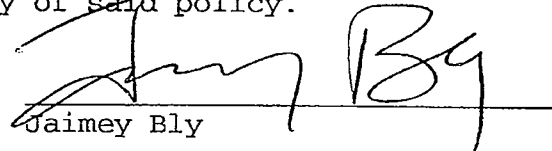


EXHIBIT

5

POLICY CERTIFICATION

The undersigned, Jaimey Bly, being the Manager of Life Policy Administration of Nationwide Life Insurance Company located in Columbus, Ohio, hereby states that the attached portions of policy number L034804300 insuring the life of Gary H. Lupiloff, constitute a true and accurate copy of said policy.


Jaimey Bly

STATE OF OHIO)
) S.S.
COUNTY OF FRANKLIN)

On this 4th day of ^{May} 2011, before me, a Notary Public in and for the State of Ohio, appeared Jaimey Bly, known to be the person described herein, and who executed the foregoing instrument and she acknowledged that she voluntarily executed the same.


Notary Public

My Commission Expires: 06-22-2011



MARGARET MODLICH
Notary Public, State of Ohio
My Commission Expires 06-22-2011



GUARANTEED TERM LIFE INSURANCE TO AGE 95 POLICY

PLEASE READ YOUR POLICY CAREFULLY

This policy is a legal contract between you and us.

MEMO TO THE POLICY OWNER:

Thank you for relying on Nationwide Life Insurance Company.

The protection this policy provides is explained on the following pages. To help us serve you better, please let us know if you change your name or address, or wish to change your Beneficiary.

We agree to pay the Death Benefit to the Beneficiary upon receiving proof that the Insured has died while this policy is in force.

10 DAY RIGHT TO EXAMINE

To be certain that you are satisfied with this policy, you have a 10-day "free look." Within 10 days after you receive the policy, you may return it to our Home Office or to the agent who delivered it. We will then void the policy as if it had never been in force and refund all premiums paid.

If you have any questions about your policy or need additional insurance service, contact your agent or write to our Home Office. When you write to us, please include the policy number, the Insured's full name, and your current address.

Signed at the Home Office of the Nationwide Life Insurance Company, One Nationwide Plaza, Columbus, Ohio on the Policy Date shown on the policy data page.

Patricia B. Hatter

Secretary

Joseph J. Hafer

President

Renewable once a year until age 95.

Convertible anytime prior to the end of the conversion period, as stated on the policy data pages.

Premiums payable during lifetime of Insured prior to the end of the term of the policy.

Premiums are guaranteed at issue.

Non-Participating - No Dividends.

Life 4608

Nationwide Life Insurance Company
Home Office: One Nationwide Plaza A Columbus, Ohio 43215-2220

DUPLICATE

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002246 880002

POLICY DATA PAGE

Owner GARY H LUPIOFF
 Insured GARY H LUPIOFF
 Policy Number L034804300
 Age Of Insured [REDACTED]
 Sex Of Insured Male
 Rate Type Non-Tobacco

Policy Date November 28, 2003
 Initial Face Amount \$500,000
 Standard Premium Class

An initial premium on the premium basis as shown in the application is due as of the policy date.
 Total initial premiums for the available frequencies of payment are:

Annual	Semi Annual	Quarterly	Monthly
\$1,030.00	\$535.60	\$272.95	\$91.67

Premiums are payable to the policy anniversary in the year shown in the schedule below or until prior death of the insured.

To determine the guaranteed maximum modal premium for any given age, use the annual premium shown and then:

1. multiply by the factor shown at the right; and
2. add the loading

Payment Mode	Factor	Loading
Semi-annual	x .5200	+ .00
Quarterly	x .2650	+ .00
PAP	x .0890	+ .00

Schedule of Benefits and Annual Premiums

Form Number	Benefits	Annual Premium	Payable To Year
4608	10 YEAR LEVEL GUARANTEED TERM LIFE INSURANCE TO AGE 65	\$1,030.00	2013
	TOTAL INITIAL ANNUAL PREMIUM	\$1,030.00	

DUPLICATE

002246880003

Insured Name GARY H LUPLOFF
 Policy Number L034804300
 Policy Date November 28, 2003
 Age Of Insured [REDACTED]
 Sex of Insured Male

10 Year Level Guaranteed Term Life Insurance to Age 95 - Base Policy

Face Amount - \$500,000

NOTE: Premium is due at the beginning of each premium payment period (i.e., Annual, Semi-Annual, Quarterly, Monthly). The premium for the annual premium payment period is disclosed on this page.

NOTE: Conversion may be at any time during the first 5 years, subject to the "CONVERSION" provision.

POLICY YEAR	AGE	GUARANTEED PREMIUM	POLICY YEAR	AGE	GUARANTEED PREMIUM
1	46	\$1,030.00	26	71	\$52,915.00
2	47	\$1,030.00	27	72	\$58,435.00
3	48	\$1,030.00	28	73	\$65,135.00
4	49	\$1,030.00	29	74	\$72,495.00
5	50	\$1,030.00	30	75	\$80,385.00
6	51	\$1,030.00	31	76	\$88,675.00
7	52	\$1,030.00	32	77	\$97,365.00
8	53	\$1,030.00	33	78	\$106,480.00
9	54	\$1,030.00	34	79	\$116,310.00
10	55	\$1,030.00	35	80	\$127,170.00
11	56	\$11,825.00	36	81	\$139,335.00
12	57	\$12,980.00	37	82	\$153,060.00
13	58	\$14,288.00	38	83	\$168,280.00
14	59	\$15,710.00	39	84	\$184,685.00
15	60	\$17,320.00	40	85	\$201,930.00
16	61	\$19,110.00	41	86	\$219,760.00
17	62	\$21,175.00	42	87	\$237,915.00
18	63	\$23,515.00	43	88	\$258,315.00
19	64	\$26,110.00	44	89	\$276,225.00
20	65	\$28,955.00	45	90	\$294,810.00
21	66	\$32,030.00	46	91	\$315,830.00
22	67	\$35,330.00	47	92	\$338,765.00
23	68	\$38,915.00	48	93	\$365,945.00
24	69	\$42,890.00	49	94	\$402,410.00
25	70	\$47,760.00			

DUPLICATE

DEFINITIONS

ATTAINED AGE: The Insured's Attained Age is equal to the Insured's age at issue, shown on the policy data page, plus the number of completed Policy Years.

BENEFICIARY: The Beneficiary is the person to whom the Death Benefits are paid when the Insured dies. The Beneficiary is named in the application, unless changed.

COMPANY: The Company is the Nationwide Life Insurance Company. "We," "our," and "us" refer to the Company.

CONTINGENT BENEFICIARY: The Contingent Beneficiary will become the Beneficiary if the named Beneficiary dies prior to the date of the death of the Insured.

CONTINGENT OWNER: The Contingent Owner will become the Owner if the named Owner dies prior to the date of death of the Insured.

DEATH BENEFIT: The Death Benefit means the amount of money payable to the Beneficiary if the Insured dies while this policy is in force.

HOME OFFICE: The Home Office of the Company is at One Nationwide Plaza, Columbus, Ohio.

INSURED: The Insured is the person whose life is covered by this insurance policy and named in the application.

OWNER: The Owner is as stated in the application unless later changed and endorsed on this policy. "You" or "your" refer to the Owner of this policy.

POLICY ANNIVERSARY: A Policy Anniversary is an anniversary of the Policy Date, shown on the policy data page.

POLICY DATE: The Policy Date is the date the policy provisions take effect. It is shown on the policy data page. Policy Years and policy months are measured from the Policy Date.

POLICY YEAR: The Policy Year starts on an anniversary of the Policy Date, and ends on the day prior to the next anniversary of the Policy Date.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT: The insurance provided by this policy is in return for the application and premiums paid as required in the policy. The policy and a copy of any written application, including any written supplemental applications together make up the entire policy contract. All agreements related to the policy must be on official forms signed by the President or Secretary of the Company. We will not be bound by any promise or representation made by any agent or other persons.

APPLICATION: All statements in an application are considered representations and not warranties. In issuing this policy, we have relied on the statements made in the application to be true and complete. No such statement will be used to void the policy or deny a claim unless that statement is a material misrepresentation.

SUICIDE: Suicide of the Insured, while sane or insane, within two years after the Policy Date, is not covered by this policy. In that event, this policy will end and the only amount payable will be the return of any paid premiums to the Beneficiary.

INCONTESTABILITY: After this policy has been in force during the lifetime of the Insured for two years from the Policy Date, we will not contest it for any reason except nonpayment of premiums. After any endorsement or rider has been in force as part of the policy during the lifetime of the Insured for two years, we will not contest it for any reason except nonpayment of premium.

ERROR IN AGE OR SEX: If the age or sex of an Insured has been misstated, all payments and benefits under the policy will be those which the premiums paid would have purchased at the Insured's correct age or sex.

ASSIGNMENT: The Owner may assign all rights under this policy. We will not be bound by the assignment until written notice is received, accepted, and recorded at our Home Office. Assignment will be subject to any amounts owed to us before the assignment was recorded. We are not responsible for the validity of any assignment.

NON-PARTICIPATION: This policy does not participate in our earnings or surplus. This policy does not earn dividends.

DEATH BENEFIT PROVISION

We will pay the Death Benefit to the Beneficiary when we receive satisfactory proof that the death of the Insured occurred while this policy was in force. The part of any premium paid past the policy month of death will be added to the amount paid on death. Any amounts owed to us under the Premium Payment Provisions will be deducted from the amount paid on death.

OWNER AND BENEFICIARY PROVISIONS

OWNERSHIP: The Owner has all rights under the policy during the lifetime of the Insured, unless otherwise provided. If the Owner dies before the Insured, the Owner's estate becomes Owner of the policy, unless the Owner has provided otherwise.

The Owner may name a Contingent Owner or a new Owner at any time during the lifetime of the Insured. Any new designation of an Owner will automatically revoke any existing designation. Any request for change must be made in writing and recorded at our Home Office. It is effective as of the date the written request is signed. It will not apply to any payment made or action taken by us before it was recorded.

BENEFICIARY: The Beneficiary and Contingent Beneficiary on the Policy Date are named in the application. More than one Beneficiary or Contingent Beneficiary may be named. If more than one Beneficiary is designated when the Death Benefit becomes payable, payment to the survivors will be made in equal shares, or in full to the last survivor, unless some other distribution of proceeds is provided.

If any Beneficiary dies or ceases to exist before the Death Benefit becomes payable, that Beneficiary's interest will be paid to any surviving Beneficiaries or Contingent Beneficiaries according to their respective interests, unless you have specified otherwise. If no Beneficiary is living or in existence when the Death Benefit becomes payable, we will consider you or your estate to be the Beneficiary.

CHANGE OF BENEFICIARY: While the Insured is living, you may change any Beneficiary or Contingent Beneficiary. Any change must be in a written form satisfactory to us and recorded at our Home Office. Once recorded, whether or not the Insured is then alive, the change will take effect as of the date you signed it. It will not affect any payment made or action taken by us before it was recorded. We may require that you send us your policy for endorsement before making a change.

PREMIUM PAYMENT PROVISIONS

Premiums are payable for the term of the policy or until the prior death of the Insured. The full premium is payable in advance, and must be paid when due to avoid loss of coverage or reduced benefits. Premiums are payable at our Home Office or to our authorized representative. The authorized representative will accept premiums and provide an official Company receipt signed by the President or Secretary and countersigned by representative. The first premium is due on the Policy Date shown on page 2. After that, premiums are due once a year, or every six months, or every three months, or once a month, depending upon the frequency of payment chosen by the Owner.

All future premiums are guaranteed. You may change the frequency of future premium payments by written request. The change must conform to premium payment rules we have in effect at that time.

PREMIUM CHANGES: All premiums are guaranteed at issue as stated in the policy data pages. The premiums are level for the period shown on the policy data pages. After the level portion of the policy, the premiums are based on an Attained Age scale and increase every year to age 95.

GRACE PERIOD: If any premium after the first one is not paid when due, a period of 31 days from the due date of the unpaid premium will be allowed for payment. The policy will continue in force during this 31 day period. However, if the Insured dies during this 31 day period, any unpaid premium will be deducted from the Death Benefit. In no event will premiums be charged past the policy month of death. This policy will lapse, without value, if premiums are not paid.

REINSTATEMENT: If this policy lapses prior to the expiration date, you may reinstate it. You must apply in writing within five years after the date the first unpaid premium was due. We must also have evidence of insurability that is acceptable to us. All overdue premiums must be paid with 6% compound interest. Compounding interest is added to the amount owed and begins to bear interest itself during the following year.

CONVERSION

This policy may be converted to a level premium, level benefit, permanent plan of whole life or endowment insurance which is currently being offered by Nationwide. Subject to the Company's approval, the conversion may also be made to certain non-level premium, permanent life insurance policies. Conversion may be at any time prior to the end of the conversion period, as stated on the policy data pages. The following will apply:

1. This policy must be in force.
2. Conversion must be applied for in writing.
3. The Insured's Attained Age must be less than 75.
4. Evidence of insurability is not needed.
5. The face amount of the new policy may be for an amount up to the face amount of this policy at the time the request for conversion is made, but not less than our published minimum for the plan selected.

6. The new policy must be for a plan of insurance we are issuing on the date of conversion.
7. Premiums for the converted policy will not be waived because of any existing disability at the time of conversion.
8. Supplemental benefits cannot be added without evidence of insurability and consent of the Company.

The Policy Date of the new policy will be the date of conversion. The premium for the new policy will be based on the same class of risk as this policy and the Attained Age of the Insured on the date of conversion.

The contestable and suicide periods in the new policy will start on the Policy Date of this policy.

POLICY SETTLEMENT

Policy settlement means payment of the Death Benefit when the Insured dies.

Policy settlement may be paid in a lump sum. Options for other methods of settlement are also available. One settlement option or a combination of options may be chosen. A settlement option other than lump sum may be chosen only if the total amount placed under the option is at least \$2,000.00 and each payment is at least \$20.00.

While this policy is in force, the Owner may choose, revoke or change settlement options at any time. If no settlement option has been chosen before the Insured has died, the Beneficiary may choose one. If no other settlement option has been chosen, payment will be made in a lump sum.

Settlement options must be chosen, revoked or changed by proper written request. After an option, revocation, or change is recorded at our Home Office, it will become effective as of the date it was requested. We may require proof of age of any person to be paid under a settlement option. Any change of Beneficiary will automatically revoke any settlement option that is in effect.

At the time of policy settlement under any settlement option other than lump sum, we will issue a settlement contract in exchange for the policy. The effective date of the settlement contract will be the date the Insured died.

Settlement option payments are not assignable. To the extent allowed by law, settlement option payments are not subject to the claims of creditors or to legal process.

Options 1, 2, 4 and the guaranteed period of Option 3, provide for payment of interest at the rate of 2-1/2% per year. We will determine once a year any interest to be paid in excess of the rate of 2-1/2%.

OPTIONS

1. **INTEREST INCOME:** Any amount payable under this option may be left with us and will receive interest of at least 2-1/2% annually. This interest may be either left to accumulate or it may be paid at the end of every 12, 6, 3, or 1 month interval from the effective date of the settlement contract. Upon receipt of proper written request, the amount left with us may be withdrawn.

2. **INCOME FOR A FIXED PERIOD:** Any amount payable under this option will be paid over the number of years selected. The amount payable monthly for each \$1,000 left with us will be at least as much as the amount shown in the Option 2 Table. If chosen, payments will be made at the beginning of each 12, 6, 3, or 1 month interval, starting with the effective date of the settlement contract. Each payment includes a portion of the amount left with us and interest. Upon receipt of proper written request, the amount left with us may be withdrawn.

3. LIFE INCOME WITH PAYMENTS GUARANTEED: Any amount payable under this option will be paid during the named payee's lifetime. A guaranteed period of 10, 15, or 20 years may be selected. Payments will continue to the end of this period even if the payee dies. The amount payable monthly for each \$1,000 left with us is shown in the Option 3 Table. If chosen, payments will be made at the beginning of each 12, 6, 3, or 1 month interval starting with the effective date of the settlement contract. Amounts left with us under this option may not be withdrawn.

4. FIXED INCOME FOR VARYING PERIODS: Any amount payable under this option will be paid in a fixed amount until the amount left under this option, and interest, has been paid. The total amount payable each year may not be less than 5% of the amount left under this option. Interest paid under this option will be at the rate of at least 2-1/2% compounded annually. If chosen, payments will be made at the beginning of each 12, 6, 3, or 1 month interval, starting with the effective date of the settlement contract. Upon receipt of proper written request, the amount left with us may be withdrawn.

5. JOINT AND SURVIVOR LIFE INCOME: Any amount payable under this option will be paid and continued during the lifetimes of the named payees, as long as either payee is living. Upon request, the Company will furnish information as to the monthly amounts payable for each \$1,000 of proceeds. (Life Income amounts payable for other combinations of age and sex will be furnished on request.) If chosen, payments will be made jointly at the beginning of each 12, 6, 3, or 1 month interval, starting with the effective date of the settlement contract. Amounts left with us under this option may not be withdrawn.

6. LIFE ANNUITY: Any amount payable under this option will be paid during the lifetime of the named payee or the lifetimes of the named payees. The amount payable will be 102% of our current annuity purchase rate on the effective date of the settlement contract. Annuity purchase rates are subject to change. Upon request, we will quote the amount currently payable under this settlement option. If chosen, payments will be made at the end of each 12, 6, 3, or 1 month interval from the effective date of the settlement contract. Amounts left with us under this option may not be withdrawn.

TABLES FOR SETTLEMENT OPTIONS**OPTION 2**

Monthly Installments for each \$1,000 of Proceeds
 Option 2 - Income for a Fixed Period

Number of Years Specified	Amount of Each Installment	Number of Years Specified	Amount of Each Installment
1	\$84.28	16	\$6.30
2	42.66	17	6.00
3	28.79	18	5.73
4	21.86	19	5.49
5	17.70	20	5.27
6	14.93	21	5.08
7	12.95	22	4.90
8	11.47	23	4.74
9	10.32	24	4.60
10	9.39	25	4.46
11	8.64	26	4.34
12	8.02	27	4.22
13	7.49	28	4.12
14	7.03	29	4.02
15	6.64	30	3.93

Annual, semi-annual or quarterly payments are 11.865, 5.969 and 2.994 respectively times the monthly installments.

OPTION 3

Monthly Installments for each \$1,000 of Proceeds
 Option 3 - Life Income with Payments Guaranteed
 REFER TO NEXT PAGE

OPTION 5

Monthly Installments for each \$1,000 of Proceeds
 Option 5 - Joint & Survivor Life Income

M/F	50	55	60	65	70	75	80	85	90	95	100
50	\$2.86	\$2.96	\$3.04	\$3.11	\$3.17	\$3.21	\$3.24	\$3.26	\$3.28	\$3.29	\$3.29
55	\$2.92	\$3.04	\$3.15	\$3.26	\$3.35	\$3.43	\$3.48	\$3.52	\$3.55	\$3.56	\$3.57
60	\$2.96	\$3.11	\$3.26	\$3.41	\$3.55	\$3.67	\$3.77	\$3.84	\$3.88	\$3.91	\$3.93
65	\$3.00	\$3.17	\$3.35	\$3.55	\$3.75	\$3.94	\$4.10	\$4.22	\$4.31	\$4.37	\$4.40
70	\$3.02	\$3.21	\$3.43	\$3.67	\$3.94	\$4.21	\$4.47	\$4.68	\$4.85	\$4.96	\$5.03
75	\$3.04	\$3.24	\$3.48	\$3.77	\$4.10	\$4.47	\$4.85	\$5.20	\$5.50	\$5.72	\$5.86
80	\$3.05	\$3.26	\$3.52	\$3.84	\$4.22	\$4.68	\$5.20	\$5.73	\$6.22	\$6.63	\$6.92
85	\$3.06	\$3.28	\$3.55	\$3.88	\$4.31	\$4.85	\$5.50	\$6.22	\$6.98	\$7.67	\$8.22
90	\$3.07	\$3.29	\$3.56	\$3.91	\$4.37	\$4.96	\$5.72	\$6.63	\$7.67	\$8.73	\$9.68
95	\$3.07	\$3.29	\$3.57	\$3.93	\$4.40	\$5.03	\$5.86	\$6.92	\$8.22	\$9.68	\$11.16
100	\$3.07	\$3.30	\$3.58	\$3.94	\$4.42	\$5.07	\$5.96	\$7.12	\$8.62	\$10.46	\$12.49

OPTION 3**Monthly Installments for each \$1,000 of Proceeds
Option 3 - Life Income with Payments Guaranteed**

Age of Payee Last Birthday		Guaranteed Period Years			Age of Payee Last Birthday		Guaranteed Period Years			Age of Payee Last Birthday		Guaranteed Period Years		
Male	Female	10	15	20	Male	Female	10	15	20	Male	Female	10	15	20
5 & under	10 & under	\$2.33	\$2.33	\$2.32	35	40	\$2.75	\$2.75	\$2.75	65	70	\$4.37	\$4.27	\$4.12
6	11	\$2.33	\$2.33	\$2.33	36	41	\$2.78	\$2.78	\$2.77	66	71	\$4.48	\$4.36	\$4.19
7	12	\$2.34	\$2.34	\$2.34	37	42	\$2.81	\$2.80	\$2.80	67	72	\$4.59	\$4.45	\$4.26
8	13	\$2.35	\$2.35	\$2.35	38	43	\$2.83	\$2.83	\$2.82	68	73	\$4.71	\$4.55	\$4.33
9	14	\$2.36	\$2.36	\$2.36	39	44	\$2.86	\$2.86	\$2.85	69	74	\$4.83	\$4.65	\$4.40

10	15	\$2.37	\$2.37	\$2.37	40	45	\$2.89	\$2.89	\$2.88	70	75	\$4.96	\$4.75	\$4.47
11	16	\$2.38	\$2.38	\$2.38	41	46	\$2.92	\$2.92	\$2.91	71	76	\$5.10	\$4.86	\$4.54
12	17	\$2.39	\$2.39	\$2.39	42	47	\$2.96	\$2.95	\$2.94	72	77	\$5.24	\$4.97	\$4.61
13	18	\$2.40	\$2.40	\$2.40	43	48	\$2.99	\$2.99	\$2.97	73	78	\$5.39	\$5.07	\$4.68
14	19	\$2.41	\$2.41	\$2.41	44	49	\$3.03	\$3.02	\$3.01	74	79	\$5.55	\$5.18	\$4.75

15	20	\$2.42	\$2.42	\$2.42	45	50	\$3.07	\$3.06	\$3.04	75	80	\$5.71	\$5.29	\$4.81
16	21	\$2.43	\$2.43	\$2.43	46	51	\$3.11	\$3.10	\$3.08	76	81	\$5.87	\$5.40	\$4.87
17	22	\$2.44	\$2.44	\$2.44	47	52	\$3.15	\$3.14	\$3.12	77	82	\$6.05	\$5.51	\$4.92
18	23	\$2.46	\$2.45	\$2.45	48	53	\$3.19	\$3.18	\$3.16	78	83	\$6.22	\$5.61	\$4.97
19	24	\$2.47	\$2.47	\$2.46	49	54	\$3.24	\$3.22	\$3.20	79	84	\$6.40	\$5.72	\$5.02

20	25	\$2.48	\$2.48	\$2.48	50	55	\$3.29	\$3.27	\$3.25	80	85	\$6.58	\$5.82	\$5.06
21	26	\$2.49	\$2.49	\$2.49	51	56	\$3.34	\$3.32	\$3.29	81	86	\$6.77	\$5.91	\$5.10
22	27	\$2.51	\$2.51	\$2.50	52	57	\$3.39	\$3.37	\$3.34	82	87	\$6.96	\$6.00	\$5.15
23	28	\$2.52	\$2.52	\$2.52	53	58	\$3.45	\$3.42	\$3.39	83	88	\$7.14	\$6.09	\$5.16
24	29	\$2.54	\$2.54	\$2.53	54	59	\$3.50	\$3.48	\$3.44	84	89	\$7.33	\$6.16	\$5.18

25	30	\$2.55	\$2.55	\$2.55	55	60	\$3.56	\$3.53	\$3.49	85	90	\$7.51	\$6.24	\$5.21
26	31	\$2.57	\$2.57	\$2.57	56	61	\$3.63	\$3.59	\$3.54	86	91	\$7.69	\$6.30	\$5.22
27	32	\$2.59	\$2.59	\$2.58	57	62	\$3.69	\$3.66	\$3.60	87	92	\$7.87	\$6.36	\$5.24
28	33	\$2.61	\$2.60	\$2.60	58	63	\$3.76	\$3.72	\$3.66	88	93	\$8.03	\$6.41	\$5.25
29	34	\$2.62	\$2.62	\$2.62	59	64	\$3.84	\$3.79	\$3.72	89	94	\$8.19	\$6.46	\$5.26

30	35	\$2.64	\$2.64	\$2.64	60	65	\$3.91	\$3.86	\$3.78	90	95	\$8.34	\$6.50	\$5.26
31	36	\$2.66	\$2.66	\$2.66	61	66	\$3.99	\$3.93	\$3.84	91	96	\$8.48	\$6.53	\$5.27
32	37	\$2.68	\$2.68	\$2.68	62	67	\$4.08	\$4.01	\$3.91	92	97	\$8.61	\$6.56	\$5.27
33	38	\$2.71	\$2.70	\$2.70	63	68	\$4.17	\$4.09	\$3.98	93	98	\$8.73	\$6.58	\$5.27
34	39	\$2.73	\$2.73	\$2.72	64	69	\$4.27	\$4.18	\$4.05	94	99	\$8.84	\$6.60	\$5.27
										95 & over	100 & over	\$8.94	\$6.61	\$5.27

If the income payable for a specific guaranteed period is equal to that for other guarantee periods the longer period will be deemed to have been elected.

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ENDORSEMENTS (Endorsements may be made only by the Company at the Home Office)

Life 4608

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☐ NATIONWIDE LIFE INSURANCE COMPANY
☐ NATIONWIDE LIFE AND ANNUITY INSURANCE COMPANY

Application for Life Insurance

P.O. Box 182835 Columbus, Ohio 43218-2835

PART A

1. PROPOSED PRIMARY INSURED:										
a. Name (First, MI, Last) <u>Gray Herman Luploff</u>					b. Social Security Number					
c. Residence Street Address (include city, state and zip code)										
d. County <u>Oakland</u>			e. Date of Birth			f. State of Birth <u>Michigan</u>				
g. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		h. Age <u>46</u>		i. Marital Status <u>Single</u>		j. Driver's License # and State of Issue				
k. Former Name (if applicable)			l. Occupation <u>Advertising Sales</u>			m. Employer <u>AKSO Insurance</u>				
n. Can you read and understand English? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			o. Citizenship (if other, submit Foreign Supplement) <input checked="" type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other			p. How long have you been in the U.S? <u>46 years</u>				
q. Telephone (Home)			r. Best time to call			s. Telephone (Business)			t. Best time to call	
			<u>5:00 AM/PM</u>						<u>AM/PM</u>	
2. PROPOSED DEPENDENT (JOINT-POSSIBLE CHILDREN) (Complete if applicable)										
NAME OF INSURED(S)		DATE OF BIRTH	AGE	SEX	HEIGHT	WEIGHT	STATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP TO INSURED	
3. JOINTSPOUSE PROPOSED INSURED ADDITIONAL INFORMATION (Complete if applicable)										
a. Residence Street Address (include city, state and zip code)										
b. Former Name (if applicable)			c. Occupation			d. Employer				
e. Driver's License # and State of Issue			f. County			g. Marital Status				
h. Can you read and understand English? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			i. Citizenship (if other, submit Foreign Supplement) <input checked="" type="checkbox"/> U.S. <input type="checkbox"/> Canada <input type="checkbox"/> Other			j. How long have you been in the U.S?				
k. Telephone (Home)			l. Best time to call			m. Telephone (Business)			n. Best time to call	
			<u>AM/PM</u>						<u>AM/PM</u>	
4. OWNER (The Primary Insured (Joint Insureds in case of Survivorship) will own the policy unless indicated here. If the Owner is a Trust, complete the Trust Information Section below.)										
a. Name (First, MI, Last)					b. Social Security Number or Tax ID					
c. Residence Street Address (include city, state and zip code)										
d. County		e. Relationship to Insured(s)			f. Telephone Number		g. Date of Birth			
(Only complete h, i, j and k for traditional life policies on lives of (ages 0-14) when applying for Owner's Death or for Owner's Death or Disability Benefits)										
h. Occupation			i. Height		j. Weight		k. State of Birth			
l. Trust Information (Please submit copy of first and signature pages of Trust document)										
EXACT NAME OF TRUST				TRUST TAX ID NUMBER		CURRENT TRUSTEE(S)		DATE OF TRUST		
5. CONTINGENT OWNER										
a. Name (First, MI, Last)					b. Social Security Number or Tax ID					
c. Residence Street Address (include city, state and zip code)										
d. County		e. Relationship to Insured(s)			f. Telephone Number		g. Date of Birth			

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(12/2002)

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6. LIFE INSURANCE PLAN			
a. Plan (If a Variable Life product is being applied for, the Variable Life Fund Supplement MUST be completed in conjunction with this application.) GT: 10			
b. Total Specified Face Amount (including Additional Protection Rider) \$ 500,000	c. Additional Protection Rider Amount: (Individual Life case only) NA	d. Supplemental Coverage Percentage (Survivorship case only) NA	
e. Initial Premium Deposit (paid with application) \$ 200.00	f. Planned Premium (Check plan for availability) <input type="checkbox"/> Single Premium \$ <input type="checkbox"/> Annual \$ <input type="checkbox"/> Monthly EFT (Complete Part A, II)		g. <input type="checkbox"/> Semi-Annual \$ <input checked="" type="checkbox"/> Quarterly \$ 197.43 <input type="checkbox"/> Monthly \$
FOR INDIVIDUAL VARIABLE UNIVERSAL LIFE PLAN ONLY (Check plan for availability)			
h. Death Benefit Option (If no option is selected here, Option 1 is elected): <input type="checkbox"/> Option 1 (The Specified Amount, or a multiple of the Cash Value, whichever is greater). <input type="checkbox"/> Option 2 (The Specified Amount, plus the Cash Value, or a multiple of the Cash Value, whichever is greater). <input type="checkbox"/> Option 3 (The Specified Amount, plus the Premium Accumulation at _____ % interest or a multiple of the Cash Value, whichever is greater).			
i. Internal Revenue Code Life Insurance Qualification Test (If no selection is made here, Guideline Premium/Cash Value Corridor Test is elected). <input type="checkbox"/> Guideline Premium/Cash Value Corridor Test <input type="checkbox"/> Cash Value Accumulation Test			
j. Optional Benefit Riders: <input type="checkbox"/> Accidental Death Benefit Rider \$ <input type="checkbox"/> Adjusted Sales Load Rider _____ % (in whole percentages only) waived for _____ years. <input type="checkbox"/> Child Rider \$ <input type="checkbox"/> Long Term Care Rider \$ <input type="checkbox"/> Maturity Extension Endorsement for Specified Amount. <input type="checkbox"/> Premium Waiver Rider \$ <input type="checkbox"/> Spouse Rider \$ <input type="checkbox"/> Waiver of Monthly Deduction Rider. <input type="checkbox"/> Other Rider(s) *Complete Supplement for Long Term Care Rider			
FOR SURVIVORSHIP LIFE PLAN ONLY (Check plan for availability)			
k. Death Benefit Option (If no option is selected here, Option 1 is elected): <input type="checkbox"/> Option 1 (The Specified Amount, or a multiple of the Cash Value, whichever is greater). <input type="checkbox"/> Option 2 (The Specified Amount, plus the Cash Value, or a multiple of the Cash Value, whichever is greater). <input type="checkbox"/> Option 3 (The Specified Amount, plus the Premium Accumulation at _____ % interest or a multiple of the Cash Value, whichever is greater).			
l. Internal Revenue Code Life Insurance Qualification Test (If no selection is made here, Guideline Premium/Cash Value Corridor Test is elected). <input type="checkbox"/> Guideline Premium/Cash Value Corridor Test <input type="checkbox"/> Cash Value Accumulation Test			
m. Optional Benefit Riders: <input type="checkbox"/> Adjusted Sales Load Rider _____ % (in whole percentages only) waived for _____ years. <input type="checkbox"/> Estate Protection Rider \$ <input type="checkbox"/> Maturity Extension Endorsement for Specified Amount. <input type="checkbox"/> Policy Split Option Rider <input type="checkbox"/> Other Rider(s)			
FOR UNIVERSAL LIFE PLAN ONLY (Check plan for availability)			
n. Death Benefit Option (If no option is selected here, Option 1 is elected): <input type="checkbox"/> Option 1 (The Specified Amount, or a multiple of the Accumulated Value, whichever is greater). <input type="checkbox"/> Option 2 (The Specified Amount, plus the Accumulated Value, or a multiple of the Accumulated Value, whichever is greater).			
o. Internal Revenue Code Life Insurance Qualification Test (If no selection is made here, Guideline Premium/Cash Value Corridor Test is elected). <input type="checkbox"/> Guideline Premium/Cash Value Corridor Test <input type="checkbox"/> Cash Value Accumulation Test			
p. Optional Benefit Riders: <input type="checkbox"/> Accidental Death - Amount \$ <input type="checkbox"/> Child Rider \$ <input type="checkbox"/> Guaranteed Option to Increase Specified Amount \$ <input type="checkbox"/> Long Term Care Rider \$ <input type="checkbox"/> Maturity Extension Endorsement for Specified Amount. <input type="checkbox"/> Spouse Rider \$ <input type="checkbox"/> Waiver of Monthly Deduction Rider. <input type="checkbox"/> Other Rider(s)			
FOR WHOLE LIFE PLAN ONLY (Check plan for availability)			
q. Optional Benefit Riders: <input type="checkbox"/> 10 Year Spouse Rider \$ <input type="checkbox"/> 20 Year Spouse Rider \$ <input type="checkbox"/> Accidental Death - Amount \$ <input type="checkbox"/> Child Rider \$ <input type="checkbox"/> Excess Credit Option <input type="checkbox"/> Guaranteed Insurability - Amount \$ <input type="checkbox"/> Owner's Death (Complete Part B, #14 for Owner). <input type="checkbox"/> Owner's Death or Disability (Complete Part B, #14 for Owner). <input type="checkbox"/> Waiver of Premium Benefit. <input type="checkbox"/> Other Rider(s) If available, issue with Automatic Premium Loan, unless indicated by checking this box <input type="checkbox"/>			
FOR TERM LIFE PLAN ONLY (Check plan for availability)			
r. Optional Benefit Riders: <input type="checkbox"/> 10 Year Spouse Rider \$ <input type="checkbox"/> 20 Year Spouse Rider \$ <input type="checkbox"/> Other Rider(s) <input type="checkbox"/> Child Rider \$ <input type="checkbox"/> Waiver of Premium Benefit			

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7. ELECTRONIC FUNDS TRANSFER AUTHORIZATION									
Financial Institution Name						Financial Institution Phone Number			
Financial Institution Address									
Account Number						Transit/ABA Number			
Monthly EFT Amount		Draft Date		<input type="checkbox"/> *Checking (Attach a pre-printed Voided Check. Starter Checks will not be accepted.) <input type="checkbox"/> *Savings (Attach a Voided Deposit Slip with account number and routing number.)					
*By providing my financial institution name and account information, I hereby authorize Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company to initiate debit entries to my checking/savings account indicated above and the Financial Institution to debit the same such account.									
8. BENEFICIARY DESIGNATIONS (If Joint Plan, specify each Primary Insured's beneficiary designation-use #19, if necessary. When more than one beneficiary is designated, payments to the beneficiaries surviving the insured will be made in equal shares, or in full to the last surviving beneficiary, unless some other distribution of proceeds is provided. If the Beneficiary is a Trust, complete the Trust Information Section below.)									
%	PRIMARY	CONTINGENT	BENEFICIARY NAME	DATE OF BIRTH	RELATIONSHIP TO INSURED(S)	SOCIAL SECURITY NUMBER			
a. Proposed Primary Insured									
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	William K. Korte		Partner (Surv.)				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marlene Lynn Korte		Daughter				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nicole Lynn Korte		Daughter				
b. Proposed Insured (Joint/Spouse)									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
c. Trust Information									
EXACT NAME OF TRUST			TRUST TAX ID NUMBER	CURRENT TRUSTEE(S)			DATE OF TRUST		
9. PAYOR (If someone other than the insured(s) or the Owner is to be billed for the premium for this policy.)									
a. Name (First, MI, Last)									
b. Residence Street Address (include city, state and zip code)									
10. INSURANCE INFORMATION									
a. Will any Life Insurance or Annuities for this or any other company be replaced, discontinued, reduced or changed if insurance now applied for is issued? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If yes, please complete appropriate replacement. If this is an Internal Revenue Code Section 1035 Exchange, please check above and attach 1035 forms. If this is a Nationwide Term Conversion and you are not the Owner of the term policy or you are not converting the entire amount of the term policy, please enclose a term conversion application.)									
b. Do you currently have any Life Insurance or Annuities in force? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If yes, please list below)									
PERSON	COMPANY	POLICY NUMBER	AMOUNT	YEAR ISSUED	ACCIDENTAL DEATH	NW TERM CONVERSION	TO BE REPLACED	1035	
			\$		\$	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
			\$		\$	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
			\$		\$	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
			\$		\$	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
			\$		\$	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
			\$		\$	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
c. Is any person here proposed for coverage now applying for Life Insurance or Annuities with any other company? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If yes, please provide name of company, amount applied for and purpose of coverage.)									

DUPLICATE

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PART B

11. PERSONAL INFORMATION

All questions are to be answered by each Proposed Insured. For each yes answer, provide details below.

	PROPOSED INSURED		JOINT/POUSE PROPOSED INSURED		ANY CHILD	
	Yes	No	Yes	No	Yes	No
a. Have you ever had any application for Life or Health Insurance (or for reinstatement for Life or Health Insurance) declined, postponed, rated-up or limited? (If yes, provide details)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b. Have you ever applied for or received disability payments for any illness or injury? (If yes, provide details)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c. In the past 3 years have you engaged in, or do you intend to engage in: flying as a pilot, student pilot, or crew member, organized racing of an automobile, motorcycle or any type of motor-powered vehicle, scuba diving, mountain climbing, hang-gliding, parachuting, sky diving, bungee jumping, or any type of body-contact or life-threatening sport? (If yes, complete an Aviation/Hazardous Activities Questionnaire)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d. Have you ever had your driver's license suspended or revoked or been convicted of driving while impaired or intoxicated, or been convicted in the past 3 years of more than one moving violation? (If yes, provide details)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e. Except as prescribed by a physician, have you ever used, or been convicted for sale or possession of cocaine or any other narcotic or illegal drug? (If yes, complete Drug Questionnaire)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f. Have you ever been charged with a violation of any criminal law? (If yes, provide details)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
g. Have you had any bankruptcies in the past 7 years or have any suits or judgments pending against you at this time? (If yes, provide details)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
h. Do you plan to travel or reside outside of the United States or Canada? (If yes, complete Supplement for Foreign Nationals or Travel)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
i. Do you belong to or intend to join any active or reserve military or naval organization? (If yes, complete Military Status Questionnaire)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
j. Do you have a parent or sibling who died from cancer or cardiovascular disease prior to age 60? (If yes, provide relationship to Proposed Insured(s), age at death and cause of death, and if cancer, provide type)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Details of any yes answers (Indicate name of person. If more space is needed, an additional blank sheet may be attached.):

5. Gary Herman Luploff 1986 Federal Bank Fraud - 1 count
 3. " " 2001 Civil Action - Settled

12. TOBACCO USE

a. PROPOSED INSURED:	
Have you used tobacco or nicotine in any form in the last 5 years? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Last 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
If yes, specify the form of tobacco or nicotine products used: <input type="checkbox"/> cigarettes <input type="checkbox"/> pipe <input type="checkbox"/> cigars <input type="checkbox"/> chewing tobacco <input type="checkbox"/> snuff <input type="checkbox"/> other tobacco <input type="checkbox"/> nicotine products (gum, patch, etc.)	
b. JOINT/POUSE PROPOSED INSURED:	
Have you used tobacco or nicotine in any form in the last 5 years? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Last 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
If yes, specify the form of tobacco or nicotine products used: <input type="checkbox"/> cigarettes <input type="checkbox"/> pipe <input type="checkbox"/> cigars <input type="checkbox"/> chewing tobacco <input type="checkbox"/> snuff <input type="checkbox"/> other tobacco <input type="checkbox"/> nicotine products (gum, patch, etc.)	

13. PHYSICAL MEASUREMENTS

INSURED	HEIGHT	WEIGHT		REASON FOR WEIGHT GAIN OR LOSS
		CURRENT	1 YEAR AGO	
Proposed Insured	5' 11" 7m	180 lbs	186 lbs	

14. PERSONAL PHYSICIAN

	PROPOSED INSURED	JOINT/POUSE PROPOSED INSURED	ANY CHILD
Name of Personal Physician:	Dr. Victor Gordon		
Address:	Frederickville, MD 20326		
Telephone Number:			
Date last consulted:	09/03		
Reason last consulted:	Neck pain		
Treatment given or medication prescribed:	Medication - Prednisone		

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To the best of your knowledge and belief, has anyone here proposed for insurance consulted a member of the medical profession for, been treated for, taken medication for, or been diagnosed as having

16. SUPPLEMENTAL MEDICAL INFORMATION

To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance.

17. DETAILS OF MEDICAL HISTORY (If more space is needed, an additional blank sheet may be attached.)

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PART C**18. TAXPAYER IDENTIFICATION NUMBER**

Under the Interest and Dividend Compliance Act of 1983, persons owning insurance policies are required to provide the Company with certification that their taxpayer identification number is correct. (For most individuals, this is their Social Security Number.) If you do not provide us with certification of this number, you may be subject to a \$50 penalty imposed by the Internal Revenue Service. In addition, we will be forced to withhold 31% from interest and other payments we make to you (known as backup withholding). It is not an additional tax, since the amount withheld may be applied against any tax you owe. If withholding results in an overpayment of taxes, a refund may be available.

☐ Check this box if the Internal Revenue Service has notified you that you are subject to backup withholding.

Otherwise, your signature on this application is certification that the taxpayer identification number on this application is true, correct, and complete. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

19. SPECIAL INSTRUCTIONS (If more space is needed, an additional blank sheet may be attached.)

APR 26 '04 17:58 FR THE REICH AGENCY 1 248 203 9009 TO 16146776189

P.02/02



L034804300

AMENDMENT
OF APPLICATION FOR INSURANCE TO
NATIONWIDE LIFE INSURANCE COMPANY
COLUMBUS, OHIO 43215

I hereby amend my application for insurance to the Nationwide Life Insurance Company on the
life of Gary Lupiloff dated November 11, 2003 as follows:

The policy was issued with Non-Tobacco rates.

I hereby agree that these changes shall be an amendment to and form a part of the original
application and of the policy issued thereunder, if any.

Signed at Bham, MI on 4/26, 2004
CITY, STATE MONTH, DAY YEAR

X [Signature] X [Signature]
SIGNATURE OF PROPOSED INSURED SIGNATURE OF OWNER
(NOT REQUIRED IF UNDER AGE 18) (IF OTHER THAN PROPOSED INSURED)
Gary Lupiloff Gary Lupiloff

Witness X [Signature]
(REPRESENTATIVE)

RETURN ORIGINAL SIGNED COPY TO NATIONWIDE

DUPLICATE

Mail To: ☒ Nationwide Life Insurance Company☐ Nationwide Life and Annuity Insurance Company☐ Life Underwriting

P.O. Box 182835

Columbus, OH 43218-2835

1-866-678-LIFE (5433)

☐ COL/BOLI, 1-11-08

One Nationwide Plaza

Columbus, OH 43215-2220

☐ Group

P.O. Box 8026

Dublin, OH 43016-9902

MEDICAL EXAMINATION(Part 2 of an application to
Nationwide Insurance
for Life or Health Insurance)

Name of Proposed Insured (please print) <u>Gary Harmon Lupilloff</u>		Social Security No. <u>[REDACTED]</u>	Date of Birth <u>[REDACTED]</u>
Physicians: Include both primary care and specialists and date last consulted. (If more than two physicians, indicate so under "details".)			
Name <u>Dr. Victor C. Ganten</u>		Name	
Address <u>28100 Old River Ave</u>		Address	
Telephone <u>248-4721-3844</u>		Telephone	
Medical specialty <u>Phys. Medicine & Rehab</u>		Medical specialty	
Date and reason last consulted <u>Walter Blood brown</u>		Date and reason last consulted	
Current medications to include prescription, over-the-counter medication taken regularly, dietary supplements, "natural" or herbal medications. Give details of dosage and frequency. <u>Celebrex Naproxen</u>			

Have you ever had any indication of, been evaluated, diagnosed, or treated by a medical professional for:

- | | Yes | No |
|---|--------------------------|-------------------------------------|
| 1a. Heart disease, including heart attack, angina or chest pain, shortness of breath, cardiomyopathy, congestive heart failure, heart murmur, or valvular heart disease, congenital heart defect, or other disorders of the heart? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Irregular heart beat, palpitations, high blood pressure, high cholesterol, or high triglycerides? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| c. Heart catheterization, abnormal electrocardiogram, or other cardiac test, coronary bypass surgery, or angioplasty? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3a. Diabetes or abnormal blood sugar? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Thyroid, adrenal, parathyroid, pituitary, or other glandular disorder? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4a. Cancer, leukemia, lymphoma or any malignant or benign tumor, cyst, or polyps? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Any abnormal screening tests for cancer including PSA (prostate specific antigen), mammogram, or PAP smears? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. AIDS (Acquired Immune Deficiency Syndrome), or received positive results of an HIV (Human Immunodeficiency Virus) test using the ELISA-ELISA-Western Blot Testing Sequence? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Disorder of the blood including anemia, sickle cell disorders, thalassemia, hemophilia, or any other disorder of the red blood cells, platelets, or clotting factors? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Stroke, TIA, paralysis, epilepsy, seizures, fainting, tremor, Parkinson's disease, mental retardation, cerebral palsy, multiple sclerosis, Alzheimer's disease, ALS (Lou Gehrig's disease), or any other symptoms or disorders of the nerves or brain? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8a. Asthma, emphysema (COPD), tuberculosis, or chronic bronchitis? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Persistent hoarseness or cough, an abnormal chest X-ray or other lung disease or disorder? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9a. Ulcer, intestinal bleeding, ulcerative colitis, Crohn's disease, diverticulitis, hernia, or any other disorder of the esophagus, stomach, or intestines? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Jaundice, cirrhosis, hepatitis, or any disease of the liver, pancreas or gall bladder? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10a. Sugar, protein, or blood in the urine, kidney stone, glomerulonephritis, or history of nephrectomy? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Other disorders of the kidney, bladder, ureter, urethra, or any part of the urinary system? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 11a. Reproductive system including uterine fibroids, endometriosis, or ovarian cyst/tumor? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Prostate enlargement, prostate cancer, testicular mass, or sexually transmitted diseases? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| c. Other disorder of the reproductive organs or breasts? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 12. Disorder of the muscles, joints, bones, tendons, ligaments, soft tissues, spine or back including arthritis, fracture, chronic pain, or herniated disc, chronic fatigue syndrome, or fibromyalgia? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 13. Disease of eyes, ears, nose, or throat? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 14a. Psychological or psychiatric disorders including depression, bipolar disorder, obsessive compulsive disorder, schizophrenia, attention deficit disorders, affective disorders, eating disorder, or any other mental or behavioral disorder or disease? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Alcoholism, drug dependency or addiction? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 15. Any other mental or physical disease or disorder not listed above? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

DETAILS of yes answers. Identify question number. Circle applicable items. Include diagnosis and name and address of medical provider(s) consulted. (Use page 2 if additional space is needed.)



Nationwide Life Insurance Company
 Nationwide Life and Annuity Insurance Company

MEDICAL EXAMINATION

(Part 2 (continued) of an application to Nationwide Insurance for Life or Health Insurance)

Have you in the past 10 years:

- | | Yes | No |
|--|-------------------------------------|--|
| 16a. Been a patient (including outpatient) in a hospital, clinic, mental health facility, or other medical facility? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Consulted or been referred to any physician not listed above? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| c. Been advised to have surgery, hospitalization, testing, or treatment that was not completed? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 17a. Used tobacco? (If yes, specify dates and form of tobacco used.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Used alcoholic beverages? (If yes, how much, what kind (beer, wine, liquor), how often?) | <input checked="" type="checkbox"/> | <input type="checkbox"/> occasional - social |
| c. Used any illegal, restricted, or controlled substance except as prescribed by a physician? (If yes, provide details.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 18. Requested or received a pension, benefits, or payment because of injury, sickness or disability? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

ADDITIONAL SPACE FOR DETAILS OF YES ANSWERS. (Identify question number.)

19.	Living	Health Concerns or Cause of Death	Age or Age at Death	Brother or Sister?	Living	Health Concerns or Cause of Death	Age or Age at Death
Father	Y <input checked="" type="checkbox"/>	Leukemia	79		<input checked="" type="checkbox"/> N		
Mother	<input checked="" type="checkbox"/> N				<input checked="" type="checkbox"/> N		

Other family members with diabetes, heart disease, cancer, kidney disease or other inheritable conditions?

All the statements and answers on this form are complete and true to the best of my knowledge and belief, whether written by my own hand or not; and I agree that they are to be the basis for any insurance issued hereon. I authorize: any licensed physician or medical practitioner; any hospital, clinic or other medical or medically related facility; any insurance company; the Medical Information Bureau; or any other organization, institution, or person who has knowledge of me (or of any other person who is proposed for insurance); to give that information to the Medical Director of the Nationwide Life Insurance Company, or its reinsurers. This authorization, or a copy of it, will be valid for a period of not more than thirty (30) months from the date it was signed.

Signed this day of March 2003
 Month Day Year

Signed _____
 Signature of Medical Examiner

Signature of Proposed Insured

001785710007

20. AGREEMENT, AUTHORIZATION AND SIGNATURES

I have read this application. I understand each of the questions. All of the answers and statements on this form are complete and true to the best of my knowledge and belief. I understand and agree that:

- A. This application, any amendments to it, and any related medical examinations will become a part of the Policy and are the basis of any insurance issued upon this application.
- B. No medical examiner, producer or other representative of Nationwide may accept risks or make or change any contract, or waive or change any of the Company's rights or requirements.
- C. If the full first premium payment is made in exchange for a Temporary Insurance Receipt, Nationwide will only be liable to the extent set forth in that receipt.
- D. If the full first premium is not paid with this application, then insurance will only take effect when all of the following conditions are met:
 1. a Policy is issued by Nationwide and is accepted by me; and
 2. the full first premium is paid; and
 3. all the answers and statements made on the application, medical examination(s) and amendments continue to be true to the best of my knowledge and belief.

The applicant has a right to cancel this application at any time by contacting their agent or Nationwide in writing. I have received the pre-notice form of the Fair Credit Reporting Act of 1970 and the Medical Information Bureau disclosure form. I certify that the Social Security Number given is correct and complete.

I authorize any licensed physician or medical practitioner, any hospital, clinic, pharmacy or other medical or medically related facility, any insurance company, the Medical Information Bureau, or any other organization, institution or person who has knowledge of me, to give that information to the Medical Director of the Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, or its reinsurers, for the purpose of underwriting my application in order to determine eligibility for Life Insurance and to investigate claims. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer be covered by federal rules governing privacy and confidentiality of health information. This authorization, or a copy of it, will be valid for a period of not more than two and one-half years (30 months) from the date it was signed. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company, Attention: Underwriting, P.O. Box 182835, Columbus, Ohio 43218-2835. I understand that a revocation is not effective to the extent that any of my providers have relied on this authorization, or to the extent that Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I further understand that if I refuse to sign this authorization to release my complete medical records, Nationwide Life Insurance Company/Nationwide Life and Annuity Insurance Company may not be able to process my application. I understand that my authorized representative or I have a right to a copy of this authorization by sending a request to Nationwide in writing.

Signed at Birmingham, Michigan, on November 11, 2003
City/State Month/Day Year

I have truly and accurately recorded all Proposed Insured's answers on this application and have witnessed her/his signature(s) hereon. To the best of my knowledge, the insurance applied for ☐ will ☒ will not (CHECK ONE) replace any life insurance, and/or annuity.

MARY E. REICH
 Producer's Name (please print)

[Signature]
 Producer's Signature

REICH Agency 21-0024503
 Firm Producer's Nationwide Number

[Redacted]
 Social Security Number

Cathy Harman Leggett
 Name of Proposed Insured (please print)

[Signature]
 Signature of Proposed Insured
 (or parent if Proposed Insured is under age 15)

[Redacted]
 Name of Joint/Spouse Proposed Insured (please print)

[Redacted]
 Signature of Joint/Spouse Proposed Insured (if to be insured)

[Redacted]
 Signature of Applicant/Owner (if other than the insured)

[Redacted]
 Signature of Payor (if other than the insured)

DUPLICATE



GUARANTEED TERM LIFE INSURANCE TO AGE 95 POLICY

Renewable once a year until age 95.

Convertible anytime prior to the end of the conversion period, as stated on the policy data pages.

Premiums payable during lifetime of Insured prior to the end of the term of the policy.

Premiums are guaranteed at issue.

Non-Participating - No Dividends.